

Quality of Life Questionnaire for Patients with Thyroid Disease

-ThyPROus-

This questionnaire is about how your thyroid disease has affected your life.

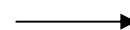
Please answer each question by marking ☐ by the answer that best fits you. If you are unsure about how you want to answer, please give the best answer you can.

The first section of the questionnaire is about symptoms, tiredness, memory, mood, and health.

Please base your **answers on how you have been feeling in general** during the past 4 weeks.

1. The first questions are about symptoms

During the past 4 weeks have you		Not at all	A little	Some	Quite a bit	Very much
		▼	▼	▼	▼	▼
1a	- had the sensation of fullness in the neck?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1b	- had a <u>visible</u> swelling in the front of your neck?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1c	- felt pressure in your throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1d	- had pain in the front of your throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1e	- had pain in your neck that could be felt in your ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1f	- had the sensation of a lump in your throat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1g	- had the need to clear your throat frequently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1h	- felt discomfort swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1i	- had difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1j	- had the sensation of suffocating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1k	- been hoarse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1l	- had trembling hands?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1m	- had a tendency to sweat a lot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1n	- experienced palpitations (rapid heart beat)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1o	- experienced shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1p	- been sensitive to heat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1q	- been sensitive to cold?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1r	- had an increased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



During the past 4 weeks have you		Not at all	A little	Some	Quite a bit	Very much
		▼	▼	▼	▼	▼
1s	- had loose stools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1t	- had an upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1u	- had moist or watery eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1v	- had bags under the eyes or swollen eyelids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1w	- had the sensation of dryness or “grittiness” in the eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1x	- had impaired vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1y	- felt pressure in (or behind) the eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1z	- had double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1aa	- had eye pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1bb	- been very sensitive to light?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1cc	- had swollen hands or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1dd	- had dry skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1ee	- had itchy skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. The following questions are about tiredness

During the past 4 weeks have you		Not at all	A little	Some	Quite a bit	Very much
		▼	▼	▼	▼	▼
2a	- been tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2b	- been exhausted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2c	- had difficulty getting motivated to do anything at all?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2d	- felt worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. *The following questions are about your vitality*

During the past 4 weeks have you		<div> <div>Not at all</div> <div>A little</div> <div>Some</div> <div>Quite a bit</div> <div>Very much</div> </div>				
		▼	▼	▼	▼	▼
3a	- felt full of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3b	- felt energetic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3c	- been able to cope with the demands of your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. *The following questions are about memory and concentration*

During the past 4 weeks have you		<div> <div>Not at all</div> <div>A little</div> <div>Some</div> <div>Quite a bit</div> <div>Very much</div> </div>				
		▼	▼	▼	▼	▼
4a	- had difficulty remembering?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b	- had slow or unclear thinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4c	- had difficulty finding the right words?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4d	- been confused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4e	- had difficulty learning something new?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4f	- had difficulty concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. The following questions are about nervousness and tension

During the past 4 weeks have you		Not at all	A little	Some	Quite a bit	Very much
		▼	▼	▼	▼	▼
5a	- felt nervous?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5b	- felt afraid or anxious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5c	- felt tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5d	- been concerned about being seriously ill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5e	- felt uneasy?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5f	- felt restless?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. The following questions are about psychological well-being

During the past 4 weeks have you		Not at all	A little	Some	Quite a bit	Very much
		▼	▼	▼	▼	▼
6a	- felt sad?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6b	- felt depressed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6c	- felt discouraged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6d	- cried easily?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6e	- felt unhappy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks have you		Not at all	A little	Some	Quite a bit	Very much
		▼	▼	▼	▼	▼
6f	- felt happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6g	- had self-confidence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. The following questions are about having difficulty coping or having mood swings

During the past 4 weeks have you

Not at all	A little	Some	Quite a bit	Very much
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7a	- had difficulty coping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7b	- felt “not like yourself”?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7c	- noticed you easily felt stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7d	- had mood swings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7e	- felt irritable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7f	- felt frustrated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7g	- felt angry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Not at all	A little	Some	Quite a bit	Completely
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7h	- felt in control of your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7i	- felt in balance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The remainder of the questionnaire is about **how your thyroid disease may have affected various aspects of your life**

8. The following questions are about your relationships with other people

During the past 4 weeks, has your thyroid disease caused you to

Not at all	A little	Some	Quite a bit	Very much
▼	▼	▼	▼	▼

8a - have difficulty being together with other people
(for example, spouse, children, boy/girlfriend,
friends, or others)? ☐ ☐ ☐ ☐ ☐

8b - feel you were a burden to other people? ☐ ☐ ☐ ☐ ☐

8c - have conflicts with other people? ☐ ☐ ☐ ☐ ☐

During the past 4 weeks have you

Not at all	A little	Some	Quite a bit	Very much
▼	▼	▼	▼	▼

8d - felt that people in your surroundings
have lacked understanding of your thyroid
disease? ☐ ☐ ☐ ☐ ☐

9. The following questions are about your daily activities

During the past 4 weeks, has your thyroid disease caused you to

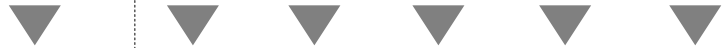
Not at all	A little	Some	Quite a bit	Very much
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- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 9a | - have difficulty managing your daily life? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9b | - limit your leisure activities or hobbies?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9c | - not be able to participate in life around you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9d | - have difficulty getting around
(for example, walking, running, bicycling,
or driving a car)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9e | - feel as if everything takes longer to do? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

During the past 4 weeks, has your thyroid disease caused you to

I do not work	Not at all	A little	Some	Quite a bit	Very much
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- | | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 9f | - have <u>difficulty managing your job</u> (for example, finding it hard
to cope or calling in sick)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

10. The following questions are about your sex life

During the past 4 weeks have you

Not at all	A little	Some	Quite a bit	Very much
▼	▼	▼	▼	▼

- 10a - felt your thyroid disease had a negative influence on your sex life? ☐ ☐ ☐ ☐ ☐
- 10b - had a decreased sexual desire? ☐ ☐ ☐ ☐ ☐

11. Thyroid diseases (or their treatment) may affect your appearance. (For example, by causing swelling of the neck, swollen face, hands, or feet, or changes in weight or to the eyes.)

During the past 4 weeks,

Not at all	A little	Some	Quite a bit	Very much
▼	▼	▼	▼	▼

- 11a - has your thyroid disease affected your appearance (for example, swelling of the neck, eye changes, weight changes)? ☐ ☐ ☐ ☐ ☐
- 11b - have you been unsatisfied with your appearance because of your thyroid disease? ☐ ☐ ☐ ☐ ☐
- 11c - have you tried to camouflage or mask visible signs of your thyroid disease (for example, by wearing a scarf or sunglasses)? ☐ ☐ ☐ ☐ ☐
- 11d - have you been bothered by other people looking at you? ☐ ☐ ☐ ☐ ☐
- 11e - has your thyroid disease influenced which clothes you wear? ☐ ☐ ☐ ☐ ☐
- 11f - has your thyroid disease made you feel too fat? ☐ ☐ ☐ ☐ ☐

12. *The final question is about to what extent your thyroid disease has affected you overall during the past 4 weeks*

During the past 4 weeks,

Not at all	A little	Some	Quite a bit	Very much
▼	▼	▼	▼	▼

12

- has your thyroid disease had a negative
effect on your quality of life?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please go back and check that you have answered all the questions.

Thank you very much for your help answering this questionnaire!